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2001STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR

LONG-TERM CARE FACILITIES (FISCAL YEAR 2001) THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY, FAILURE TO PROVIDE

IMPORTANT NOTICE

OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 004402	24			II. CERTI	FICATION BY AUTHORIZED FACILITY OFFICER				
	Facility Name: SAINT CLARE HOME Address: 5533 N. GALENA ROAD PEORIA HEIGHTS 61614 Number City Zip Code			I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/00 to 09/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with						
	County: PEORIA Telephone Number: (309)682-5428 Fay # ()				applicable instructions. Declaration of preparer (other than provider is based on all information of which preparer has any knowledge					
	Telephone Number: (309)682-5428 Fax # () IDPA ID Number: 370813229001					ntional misrepresentation or falsification of any informatior cost report may be punishable by fine and/or imprisonment				
	Date of Initial License for Current Owners:	09/01/98			Officer or	(Signed) (Date)				
	Type of Ownership:				Administrator	(Type or Print Name) Peter Bolt III				
	xx VOLUNTARY,NON-PROFIT	PROPRIETARY	GOVERNM	ENTAL	of Provider	(Title) Administrator				
	xx Charitable Corp.	Individual	State							
	Trust	Partnership	County	7		(Signed)				
	IRS Exemption Code	Corporation	Other			(Date)				
		"Sub-S" Corp.			Paid	(Print Name CRAIG L. ATER				
		Limited Liability Co.			Preparer	and Title)				
		Trust Other				(Firm Name Heritage Enterprises				
		Other				& Address)				
						,				
						(Telephone) (309)823-7135 Fax # () MAIL TO: OFFICE OF HEALTH FINANCE				
	In the event there are further questions about this report, please contact:				ILLINOIS DEPARTMENT OF PUBLIC AID					
	Name: CRAIG L. ATER	Telephone Number: ()				201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630				

DPA 3745 (N-4-99)

STATE OF ILLINOIS Page 2

r SAINT CLA	KE HUME					
DATA					# 0044024 Report Period Beginning: 10/01/00 Ending: D. How many bed-hold days during this year were paid by Public Aid?	09/30/0
	C 1	6 1 1 . // 1 . 1 .				
* * *		• .			(Do not include bed-hold days in Section B.)	
ith license). Date of	change in licensed b	eds		-		
_		_				
2		3	4		7 1 107	
					none	
					F. Does the facility maintain a daily midnight census?	
Level of	Care	Report Period	Report Period			
					• •	
	,	60	21,900		'	
	· ,	24	12 410		YES NO XX	
	(/	34	12,410		H. D 4b. DALANCE CHEET (17) 0 4	
		4	1 460			
	. ,	· ·	1,400	_	TES NO AX	
TCT/DD TO	or Ecss			+ •	1. On what date did you start providing long term care at this location?	
TOTALS		98	35,770	7	Date started 09/98	
he entire report per					J. Was the facility purchased or leased after January 1, 1978? YES xx Date 09/98 NO	
2	3	4	5		YES xx Date 09/98 NO	
2 Patient Days		•	· ·		YES xx Date 09/98 NO	
2 Patient Days Public Aid	3 by Level of Care and	d Primary Source of	Payment		YES	1 715
2 Patient Days Public Aid Recipient	3 by Level of Care and Private Pay	d Primary Source of	Payment Total	8	YES xx Date 09/98 NO	1,715
2 Patient Days Public Aid	3 by Level of Care and	d Primary Source of	Payment	8	XX Date 09/98 NO K. Was the facility certified for Medicare during the reporting year? YES XX NO If YES, enter number of beds certified and days of care provided	1,715
2 Patient Days Public Aid Recipient	3 by Level of Care and Private Pay	d Primary Source of	Payment Total	9	YES	1,715
2 Patient Days Public Aid Recipient	3 by Level of Care and Private Pay	d Primary Source of	Payment Total	_	XX Date 09/98 NO K. Was the facility certified for Medicare during the reporting year? YES XX NO If YES, enter number of beds certified and days of care provided	1,715
2 Patient Days Public Aid Recipient	3 by Level of Care and Private Pay	d Primary Source of	Payment Total	9	XES	1,715
2 Patient Days Public Aid Recipient 16,873	by Level of Care and Private Pay 13,303	Other 1,715	Payment Total 31,891	9 10 11	XX Date 09/98 NO K. Was the facility certified for Medicare during the reporting year? YES XX NO If YES, enter number of beds certified and days of care provided Medicare Intermediary Mutual of Omaha IV. ACCOUNTING BASIS	1,715
2 Patient Days Public Aid Recipient 16,873	by Level of Care and Private Pay 13,303	Other 1,715	Payment Total 31,891	9 10 11 12	XES	1,715
Patient Days Public Aid Recipient 16,873 875	3 by Level of Care and Private Pay 13,303 532	Other 1,715 0 1,715	Payment Total 31,891 1,407	9 10 11 12 13	K. Was the facility certified for Medicare during the reporting year? YES	1,715
Patient Days Public Aid Recipient 16,873 875	3 by Level of Care and Private Pay 13,303	Other 1,715 0 1,715	Payment Total 31,891 1,407	9 10 11 12 13	XES	1,715
	ctification level(s) of ith license). Date of Licensu Level of Skilled (SNI Skilled Pedi Intermediat Sheltered C ICF/DD 16	rtification level(s) of care; enter number ith license). Date of change in licensed b 2 Licensure Level of Care Skilled (SNF) Skilled Pediatric (SNF/PED) Intermediate (ICF) Intermediate/DD Sheltered Care (SC) ICF/DD 16 or Less	trification level(s) of care; enter number of beds/bed days, ith license). Date of change in licensed beds 2 3 Licensure Beds at End of Report Period Skilled (SNF) 60 Skilled Pediatric (SNF/PED) Intermediate (ICF) 34 Intermediate/DD Sheltered Care (SC) 4 ICF/DD 16 or Less	trification level(s) of care; enter number of beds/bed days, ith license). Date of change in licensed beds 2	2 3 4	rtification level(s) of care; enter number of beds/bed days, ith license). Date of change in licensed beds 2 3 4 Licensure Level of Care Beds at End of Report Period Report Period Skilled (SNF) Skilled Pediatric (SNF/PED) Intermediate (ICF) Sheltered Care (SC) ICF/DD 16 or Less 0 (Do not include bed-hold days in Section B.) E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) none F. Does the facility maintain a daily midnight census? G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO XX H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO XX I. On what date did you start providing long term care at this location?

	G/L	RECAP CENSUS	DIFF	
PP	14085	14085		0
IPA	18008	18008		0
medicare	1715	1715		0
	33808	33808		
IPA BEDHOLDS	260			
PP BEDHOLDS	250			
PP CONVERS	0			

			Page 3			
Facility Name & ID Number	SAINT CLARE HOME	# 0044024	Report Period Beginning:	10/01/00	Ending:	09/30/01

	V. COST CENTER EXPENSES (thro	oughout the rep	ort, please rour	d to the neares	t dollar)		•	0 0				•
	,		Costs Per Gener	al Ledger	ĺ	Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			İ
	A. General Services	1	2	3	4	5	6	7	8	9	10	İ
1	Dietary	187,343	18,773	0	206,116		206,116	0	206,116			1
2	Food Purchase		152,849		152,849		152,849	0	152,849			2
3	Housekeeping	97,635	10,459		108,094		108,094	0	108,094			3
4	Laundry	31,459	6,821		38,280		38,280	0	38,280			4
5	Heat and Other Utilities			83,669	83,669		83,669	0	83,669			5
6	Maintenance	65,850	38,751	31,132	135,733		135,733	0	135,733			6
7	Other (specify):*							0				7
8	TOTAL General Services	382,287	227,653	114,801	724,741		724,741		724,741			8
	B. Health Care and Programs	ŕ	,	,			,		,			
9	Medical Director			3,600	3,600		3,600	0	3,600			9
10	Nursing and Medical Records	1,184,337	152,490	113,669	1,450,496		1,450,496	0	1,450,496			10
10a	Therapy		99,320	184,787	284,107	(107,906)	176,201	0	176,201			10a
11	Activities	49,784	1,903	250	51,937		51,937	0	51,937			11
12	Social Services	33,128	138	875	34,141		34,141	0	34,141			12
13	Nurse Aide Training	0	0					0				13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16		1,267,249	253,851	303,181	1,824,281	(107,906)	1,716,375		1,716,375			16
	C. General Administration											
17	Administrative	60,000			60,000		60,000	0	60,000			17
18	Directors Fees							0				18
19	Professional Services			274,098	274,098		274,098	(4,043)	270,055			19
20	Dues, Fees, Subscriptions & Promotion			87,265	87,265	(51,465)	35,800	(6,728)	29,072			20
21	Clerical & General Office Expenses	132,854	14,654	18,942	166,450		166,450	0	166,450			21
22	Employee Benefits & Payroll Taxes			410,758	410,758		410,758	0	410,758			22
23	Inservice Training & Education			300	300		300	0	300			23
24	Travel and Seminar			3,724	3,724		3,724	(1,725)	1,999			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			3,108	3,108		3,108	0	3,108			26
27	Other (specify):*			39,715	39,715		39,715	(39,715)				27
28	TOTAL General Administration	192,854	14,654	837,910	1,045,418	(51,465)	993,953	(52,211)	941,742			28
20	TOTAL Operating Expense	1 943 700	407.159	1 255 802	7.504.440	(150.271)	7 475 0/0	(53.311)	7 707 050			20
29	(sum of lines 8, 16 & 28)	1,842,390	496,158	1,255,892	3,594,440	(159,371)	3,435,069	(52,211)	3,382,858			29

29 (sum of lines 8, 16 & 28) 1,842,390 496,158 1,255,892 3,594,440 (159,371) 3,435,069 (52,211) 3

*Attach a schedule it more than one type of cost is included on this line, or if the total exceeds \$1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification

10/01/00

Ending:

09/30/01

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning:

V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			263,361	263,361		263,361	0	263,361			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			25,344	25,344		25,344	(25,344)				32
33	Real Estate Taxes			0				0				33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles			10,195	10,195		10,195	(4,756)	5,439			35
36	Other (specify):*							0				36
37	TOTAL Ownership			298,900	298,900		298,900	(30,100)	268,800			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					107,906	107,906	0	107,906			39
40	Barber and Beauty Shops	0	69	20,479	20,548		20,548	0	20,548			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee					51,465	51,465	0	51,465			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		69	20,479	20,548	159,371	179,919		179,919	•		44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,842,390	496,227	1,575,271	3,913,888	0	3,913,888	(82,311)	3,831,577			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number SAINT CLARE HOME SAINT CLARE HOME SAINT CLARE HOME STATE OF ILLINOIS Report Period Beg

ARE HOME # 0044024 Report Period Beginning: 10/01/00

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	In column 2	below, reference the line on w	nich the	particular cost v	vas inc
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,756)	35		5
6	Rented Facility Space	0	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	0	30		9
10	Interest and Other Investment Income	(25,344)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	0	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions	0	33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(57)	20		17
18	Fines and Penalties	` `			18
19	Entertainment	(1,725)	24		19
20	Contributions	(129)	27		20
21	Owner or Key-Man Insurance	` ′		†	21
22	Special Legal Fees & Legal Retainers	(4,043)	19	1	22
23		(): -3)		1	23
24		(39,586)	27	1	24
25	Fund Raising, Advertising and Promotional	(6,671)	20	1	25
	Income Taxes and Illinois Personal	(3):)		1	
26	Property Replacement Tax				26
27				1	27
28	Yellow Page Advertising			1	28
29	Other-Attach Schedule			1	29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (82,311)		\$	30

	OHF USE ONLY					
48		49	50	51	52	

Print Preview

VI. ADJUSTMENT DETAIL

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS	S		
37	TOTAL ADJUSTMENTS (A) and (B))	s (82,311))	37
	•			•

Page 5

09/30/01

Ending:

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

1 2 3

(~-		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

| Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name |

Print Other Adjustments

	Ending: 0938/91					batton
			Sek. V Line			
	NON-ALLOWABLE EXPENSES	Amount	Reference			
	nformation listed in B13 thru. G43 is from Pay			Sub-V	Adj. Summary	
- 1	Day Care	0		Line 1		
2	Other Care for Outputionts	0		Line 2		1
3	Generalmental Spengered Special Programs			Line 3		
4	Non-Patient Meals	0		Line 4		
5	Telephone, TV & Radio in Resident Rooms	(4,756)	35	Line 5		1
	Rested Facility Space	0	34	Line 6		1
2	Sale of Supplies to Non-Patients	0		Line 7		
1	Laundry for Non-Patients	0		Line 8		
	Non-Straightline Depreciation	0	30	Line 9		
10	Interest and Other Investment Income	(25,346)	32	Line 10		1
11	Discounts, Allowances, Robates & Refunds	0		Line 18a		
12	Non-Working Officer's or Owner's Sulary	0		Line 11		
	Sales Tax	0	2	Line 12		
14	Non-Care Related Interest		32	Line 13		
15	Non-Care Related Owner's Transactions	0	33	Line 14		
16	Personal Expenses (Including Transportation		24	Line 15		
17	Non-Care Related Fees	(57)	20	Line 16		
14	Fines and Proudies			Line 17		
	Entertainment	(1,725)	24	Line 18	- 0	
29	Contributions	(129)	27	Line 19	(4.043)	
20	Owner or Key-Man Incorpance			Line 20	46.779	
	Special Level Fors & Level Betainers	(6.047)	19	Line 21	- 0	
23	Maloractice Incurance for Individuals	0		Line 22		
24	Red Dybs	(29.596)	27	Line 23		
15	Fund Raisine, Advertisine and Premotional	(6.671)	20	Line 24	(1.725)	
	Income & II. Personal Present: Rentacement			Line 25	- 0	
22	Name Aids Training for Non-Employees	0		Line 26		
25	Yellow Pare Advertising	0		Line 27	(29.715)	
24	Non-Paid Workers			Line 28	(52,211)	
	Donated Goods			Line 29	(52.211)	
	Americation Exercise			Line 30		
32			-	Line 31	- 0	
33				Line 32	(25.344)	
14				Line 33	- 6	
35				Line 34	0	
36				Line 35	44.756	
37				Line 36		
25				Line 37	(20,100	
20				Line 38		
40				Line 39	- 0	
41				Line 60	- 0	
42				Line-61		
43				Line 42	0	
44				Line 43	- 0	
45				Line 44	- 0	
46				Line 45	(82311)	
42						

blives bl

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/00 **Ending:** 09/30/01 SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 61 SUMMARY **Print Summary A** TOTALS **Operating Expenses** PAGES PAGE PAGE **PAGE** PAGE **PAGE** PAGE **PAGE** PAGE PAGE PAGE A. General Services 5 & 5A 6B 6C 6D **6E** 6F 6H (to Sch V, col.7) 6A 6G Dietary 0 1 2 Food Purchase 3 Housekeeping 4 Laundry 5 Heat and Other Utilities 6 Maintenance 7 Other (specify):* 8 TOTAL General Services B. Health Care and Programs 9 Medical Director 10 Nursing and Medical Records 0 10a 10a Therapy 0 11 11 Activities 12 Social Services 13 Nurse Aide Training 14 Program Transportation 15 Other (specify):* 16 TOTAL Health Care and Programs C. General Administration 17 Administrative 0 17 0 18 18 Directors Fees 19 Professional Services (4,043)(4,043) 19 (6,728) 20 20 Fees, Subscriptions & Promotions (6.728)21 Clerical & General Office Expenses 0 21 22 Employee Benefits & Payroll Taxes 0 22 23 Inservice Training & Education 0 23 24 Travel and Seminar (1,725)(1,725) 24 25 Other Admin. Staff Transportation 0 25 26 Insurance-Prop.Liab.Malpractice 27 Other (specify):* (39,715) 27 (39,715)

(52,211) 28

(52,211) 29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.

28 TOTAL General Administration

TOTAL Operating Expense 29 (sum of lines 8,16 & 28)

2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.

(52,211)

(52,211)

- 3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
- 4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
- 5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number SAINT CLARE HOME

0044024 Report Period Beginning:

10/01/00 Ending:

Summary B 09/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

nmary B	3												SUMMARY	П
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6 I	(to Sch V, col	.7
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	T
32	Interest	(25,344)	0	0	0	0	0	0	0	0	0	0	(25,344)	,
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	T
35	Rent-Equipment & Vehicles	(4,756)	0	0	0	0	0	0	0	0	0	0	(4,756)	,
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	Ī
37	TOTAL Ownership	(30,100)	0	0	0	0	0	0	0	0	0	0	(30,100)	Į
	Ancillary Expense													I
	E. Special Cost Centers													Ī
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	Ī
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	Ī
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	Ī
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	Ī
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	Ī
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	Ī
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	Ī
	GRAND TOTAL COST													Ī
45	(sum of lines 29, 37 & 44)	(82,311)	0	0	0	0	0	0	0	0	0	0	(82,311)	,

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

- 1. Enter the information on pages 5 and 5A.
- 2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
- 3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
- 4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
- 5. The amounts in the column Q are linked to page 4.

SET HE PROCESSES AT THE ROTTON OF THE MORNANDET. FETHEN AND MOTOR THE PROCESSES AT THE ROTTON OF THE MORNANDET AND

VII. I	Show Pg	ATED PARTIES Show Pgs 64 thru 60 Show Pgs 62 thru 61 Hide Pgs 64 thru 61 Hide Pgs 64 thru 61 ATED PARTIES are below the names of ALL owners and related croanizations (parties) as defined in the instructions. Attach an additional schedule if necessary.										
Α.	Enter below the names of ALL	owners and rela	ited organizations (parties) as defined in the i	nstructions. Attach an a	idditional schedule it	necessary.					
				2			3					
	OWNERS			RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES						
Nan	u .	Ownership %	Name		City	Name	City	Type of Business				
							·					
R.	Are any costs included in this report v		transactions with relate	d organizations? This includes re	ut,							

					ust be fully itemized in accordance with				
_	the isst	rections	for determining costs as specified for						
	1	2	3 Cost Per General Ledger	- 4	5 Cost to Related Organization	- 6	7	5 Difference:	
		dear again with the amount moderal are last Artholode VI. 1. That the information on pages 5 and 5.4. 1. That the information on pages 5 and 5.4.		Percent	Operating Cost	Adjustments for			
Schee	dule V	Line	ltem .	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	v						5		-
-	v					_			2
÷	÷					_			í
-	÷					_			3
-	v					_			6
1	Ý								7
8	v								8
9	v								9
29	v								20
11	v								11
12	v								12
13	- v	_							13
34	Tetal			P .			s	s *	14
view	Tetal	1. 2. 3. 4.	OT USE DRAG & DROP, CUT of Enter the information on page For pages 6 thru 61, the inform For pages 6 thru 61, a line can For pages 6 thru 61, related on	OR MOVE COMMA is 5 and 5A. nation you enter do be referenced as in ganization costs for	es not need to be sorted by line reference, nany times as needed per page. therapy must be referenced as line number 10a.				
		5.	The adjustments entered on the	is page will autom	atically transfer to the summary pages.				

Sum_6

STATE OF ILLINOIS Page 7

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/00 Ending: 09/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5		6	7		8	
						Average Hou	urs Per Work				
					Compensation	Week Dev	oted to this	Compensa	tion Included	Schedule V.	
					Received	Facility and	d % of Total	in Cos	ts for this	Line &	
				Ownership	From Other	Work	Week		ing Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

STATE OF ILLINOIS Page 8

	Facility Name	e & ID Number SAINT C	LARE HOME		# 0044024 R	Report Period Beginning	: 10/01/00	Ending:	09/30/01	
	VIII. ALLOC	CATION OF INDIRECT COST	Show Pgs 8A thru 8D	Show Pgs 8E th	nru 8I Hide Pgs	s 8A thru 8I				
							lated Organization			
		ere any costs included in this rep			ral office	Street Addr				
	or pare	ent organization costs? (See inst	ructions.) YES	NO		City / State Phone Num	/ Zip Code			
	D Chow t	he allocation of costs below. If r	accessory places attach world	ahaata		Fax Numbe		<u> </u>		
	b. Show th	ne anocation of costs below. If i	iecessary, piease attach work	sneets.		rax Numbe	r <u>(</u>)		
	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e., Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	Keierence	Item	Square Feet)	Total Ullits	Anocated Among	Anocateu	S III Column o	Units	(CO1.0/CO1.4)X CO1.0	1
2						Ψ	Ψ		Ψ	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13 14										13 14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					I \$	\$		\$	25

10/01/00

Ending:

09/30/01

0044024 Report Period Beginning:

SAINT CLARE HOME

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

Facility Name & ID Number

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	•	3	4	5	6	7	8	9	10	
	Name of Lender	Related	**	Purpose of Loan	Monthly Payment	Date of	Am	ount of Note	Maturity Date	Interest Rate	Reporting Period Interest	
		YES		•	Required	Note	Original	Balance		(4 Digits)	Expense	
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						s	\$			\$	9
	B. Non-Facility Related*											
10	Interest Income											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			s	14
15	TOTALS (line 9+line14)						\$	\$			\$ 0	15

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Page 10 09/30/01 # 0044024 Report Period Beginning: 10/01/00 Ending:

Facility Name & ID Number SAINT CLARE HOME IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued) B. Real Estate Taxes

. Real Estate Tax accrual used on 2000 report.	must accompany the	e the next worksheet, "RE_Tax". The cost report.	ne real	estate tax statement and bill	s	
2. Real Estate Taxes paid during the year: (Indicate	the tax year to which this payment a	applies. If payment covers more than one year,	r, detail	pelow.)	\$	
. Under or (over) accrual (line 2 minus line 1).					\$	
. Real Estate Tax accrual used for 2001 report. (D	etail and explain your calculation of	f this accrual on the lines below.)			\$	NAME .
. Direct costs of an appeal of tax assessments whice (Describe appeal cost below. Attach c	-				\$	
classified as a real estate tax cost plus one-half of TOTAL REFUND \$For	any remaining refund.	appeal costs ach a copy of the real estate tax app	oeal bo	ard's decision.)	\$	
*	any remaining refund. 19 Tax Year. (Atta	ach a copy of the real estate tax app	oeal bo	ard's decision.)	\$ \$	
classified as a real estate tax cost plus one-half of TOTAL REFUND \$ For	any remaining refund. 19 Tax Year. (Atta	ach a copy of the real estate tax app	peal bo	ard's decision.)	\$	
classified as a real estate tax cost plus one-half of TOTAL REFUND \$ For Real Estate Tax expense reported on Schedule V. Real Estate Tax History:	any remaining refund. 19 Tax Year. (Atta line 33. This should be a combinat	ach a copy of the real estate tax app tion of lines 3 thru 6.	peal bo	ard's decision.) FOR OHF USE ONLY	s s	
classified as a real estate tax cost plus one-half of TOTAL REFUND \$ For Real Estate Tax expense reported on Schedule V. Real Estate Tax History:	Tany remaining refund. 19	ach a copy of the real estate tax app tion of lines 3 thru 6.			\$ \$	s
classified as a real estate tax cost plus one-half of TOTAL REFUND \$ For Real Estate Tax expense reported on Schedule V. Real Estate Tax History:	Tany remaining refund. 19 Tax Year. (Attaution), line 33. This should be a combinate sh	ach a copy of the real estate tax app tion of lines 3 thru 6.	13	FOR OHF USE ONLY		s s
classified as a real estate tax cost plus one-half of TOTAL REFUND \$For 7. Real Estate Tax expense reported on Schedule V	19	ach a copy of the real estate tax app tion of lines 3 thru 6.	13	FOR OHF USE ONLY FROM R. E. TAX STATEMENT FOR 2		<u>- </u>

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 6/2763

Please send these items in with your completed 2001 cost report. The cost report will not be considered comple and timely filed until this statement and the corresponding real estate tax bills are filed. If you have an

To Print this page only

Hold down Control Key and hit r

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME		COUNTY	
FACILITY IDPH LICENSE NUMBER			
CONTACT PERSON REGARDING T	HIS REPORT		
TELEPHONE ()	FAX #: ()	=
A. Summary of Real Estate Tax C	<u>Cost</u>		
of the cost that applies to the operation the nursing home property which is vac	ate tax assessed for 2000 on the lines pro of the nursing home in Column D. Real ant, rented to other organizations, or used Do not include cost for any period other	estate tax applicable to an	y portion of
(A)	(B)	(C)	(D) Tax
			Applicable to
Tax Index Number	Property Description	Total Tax	Nursing Hom
1.		\$	\$
2.		\$	s
3.		\$	s
4. 5.		\$	s
6.		<u> </u>	<u>-</u>
7.		\$	s
8.		\$	s
9.		\$	s
10.		\$	\$
	TOTALS	\$0	S0
D. D. LE. (T. C. (All. d.			
B. Real Estate Tax Cost Allocation	<u>ns</u>		
Does any portion of the tax bill apply to used for nursing home services?	more than one nursing home, vacant pro		is not directly
· · · · · · · · · · · · · · · · · · ·	tule which shows the calculation of the c be allocated to the nursing home based u		g home.

 $Attach\ a\ copy\ of\ the\ 2000\ tax\ bill\ swhich\ were\ listed\ in\ Section\ A\ to\ this\ statement.\ Be\ sure\ to\ use\ the\ 2000\ tax\ bill\ swhich\ is\ normally\ paid\ during\ 2001.$

C. Tax Bills

STATE OF ILLINOIS Page 11 Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/00 Ending: 09/30/01 X. BUILDING AND GENERAL INFORMATION: A. Square Feet: 41,910 **B.** General Construction Type: Exterior Brick/Wood Frame **Number of Stories** C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions. D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions. E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable) F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO If so, please complete the following: 1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred: Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.) XI. OWNERSHIP COSTS: 2 3

Year Acquired

1998

Cost

224,000

224,000

2

Square Feet

Print Preview

Use

Land

2

3 TOTALS

A. Land.

STATE OF ILLINOIS Page 12 09/30/01 Facility Name & ID Number SAINT CLARE HOME 0044024 **Report Period Beginning:** 10/01/00 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

4 5 6 7 8	Beds*	FOR OHF USE ONLY	2 Year Acquired	Year	4	5 Current Book	6 Life	6, 1,1	8	9	j
5 6 7	98	FOR OHF USE ONLY				Current Rook	Life				
5 6 7	98		Acquired				-	Straight Line		Accumulated	
5 6 7				Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
7	0				\$ 2,682,500	\$		\$	\$	\$	4
7	0				0						5
	· ·				0						6
8											7
											8
		vement Type**									
9	Smoke Detecto	r		1999	1,932						9
	Call Light Sys			1999	16,785						10
	Sewage Ejecto			1999	3,800						11
	Door Alarm S			1999	1,275						12
13	Chapel Renova	ation		1999	1,760						13
14											14
15	Wallpaper/Pai	ntRemodel Hallways		2000	45,058						15
16	Heat / Cool Pu	mpRooftop A/C		2000	8,790						16
17	Corridor Reno	vation		2000	19,472						17
	Cubicle Curta			2000	4,020						18
19	Flooring Ha	llways		2000	45,048						19
20	Rooftop A/C U	nits		2000	328,932						20
21	Window Treat	ments		2000	7,221						21
22	Sign			2000	720						22
23	Chapel Renova	ation		2000	32,210						23
24	Smoke Detecto	ors		2000	3,300						24
25											25
26	Wallpaper/Pai	ntRemodel Hallways		2001	8,820						26
27	Door Alarm			2001	12,678						27
28	Auto Door Op	ener		2001	1,919						28
29	Vinyl Floor Co	overings North and West Wing Rooms		2001	73,863						29
30	Vinyl Floor Co	overings - North and West Wing Rooms	Labor	2001	3,750						30
31	Rooftop A/C U	nits		2001	88,341						31
32	Flooring Ha	llways		2001	3,418						32
33											33
34											34
35	Book Deprecia	tion				206,328		206,328		528,599	35
36	•					,				,	36

[&]quot; I otal beds on this schedule must agree with page 2.

See rage 12A, Line /U for total

0 Page 12B

0 Page 12C

0 Page 12D

0 Page 12E

0 Page 12F

0 Page 12G

O Page 12H

0 Page 12I

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12A 09/30/01 Facility Name & ID Number SAINT CLARE HOME # 0044024 10/01/00 Ending: Report Period Beginning:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	\top
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
37								37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 3,395,612	\$ 206,328		\$ 206,328	\$ 0	\$ 528,599	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12B 09/30/01 Facility Name & ID Number SAINT CLARE HOME 0044024 10/01/00 Ending: Report Period Beginning:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3		4	5	6	7	8	9	
	Year			Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed		Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
Improvement Type** 1 Totals from Page 12A, Carried Forward		\$	3,395,612	\$ 206,328		\$ 206,328	\$	\$ 528,599	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29 30	ļ	1				ļ	ļ		29 30
31	ļ								31
32	ļ	1				ļ	ļ		31
33		-		1	1				33
	ļ		2 20 5 (12	0 206 220		0 206 220		Ø #20 #00	
34 TOTAL (lines 1 thru 33)		\$	3,395,612	\$ 206,328		\$ 206,328	\$ 0	\$ 528,599	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12C 10/01/00 Ending: 09/30/01 Facility Name & ID Number SAINT CLARE HOME 0044024 Report Period Beginning:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
Improvement Type** 1 Totals from Page 12B, Carried Forward		\$ 3,395,612	\$ 206,328		\$ 206,328	\$	Depreciation \$ 528,599	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
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14								14
15								15
16								16
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18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29 30								29 30
31								30
32								31
32 33								32 33
34 TOTAL (lines 1 thru 33)		\$ 3,395,612	\$ 206,328		\$ 206,328	\$ 0	\$ 528,599	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12D 09/30/01 Facility Name & ID Number SAINT CLARE HOME 0044024 10/01/00 Ending: Report Period Beginning:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	<u> </u>	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
Improvement Type** 1 Totals from Page 12C, Carried Forward		\$ 3,395,612	\$ 206,328		\$ 206,328	\$	Depreciation \$ 528,599	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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25 26								25 26
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27								27
28 29								28 29
30								30
31	ļ		1	1		1		31
32								32
33								33
	ļ					1_		
34 TOTAL (lines 1 thru 33)		\$ 3,395,612	\$ 206,328		\$ 206,328	\$ 0	\$ 528,599	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

10/01/00 Ending: Page 12E 09/30/01

To Print this page only

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		STATE OF IL					Page 12E	
Facility Name & ID Number SAINT CLARE HOME			# 0044024	Report Perio	od Beginning:	10/01/00 E	nding: 09/30/01	
XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (Se	ee instructions.) Roun	d all numbers to r	earest dollar					
1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12D, Carried Forward		3,395,612	\$ 206,328		\$ 206,328	\$	\$ 528,599	1
2		· / /					,	2
3								3
4								4
5								- 5
6								6
7								7
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29				ļ				29
30				ļ				30
31				ļ				31
32				ļ				32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,395,612	\$ 206,328		\$ 206,328	\$ 0	\$ 528,599	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Report Period Beginning:

10/01/00 Ending: Page 12F 09/30/01

To Print this page only

Facility Name & ID Number SAINT CLARE HOME
XI. OWNERSHIP COSTS (continued)

0044024

Hold down Control Key and hit w

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12E, Carried Forward		\$ 3,395,612	\$ 206,328		\$ 206,328	\$	\$ 528,599	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21 22								21
22 23								22
23 24								23
25								25
26								
27								26 27
28								28
29				1		1		29
30				1		1		30
31			 	1		 		31
32			 	1		 		32
33			_	 		_		33
		0 2205 (12	0 206 220		0 206 220			
34 TOTAL (lines 1 thru 33)		\$ 3,395,612	\$ 206,328		\$ 206,328	\$ 0	\$ 528,599	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Report Period Beginning:

10/01/00 Ending: Page 12G 09/30/01

To Print this page only

Hold down Control Key and hit k

Facility Name & ID Number SAINT CLARE HOME
XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	3	1	4	5	6	7	8	9	
	Year			Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed		Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12F, Carried Forward		\$	3,395,612	\$ 206,328		\$ 206,328	S	\$ 528,599	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24 25
25									
26 27		<u> </u>			1				26 27
28		 			1				28
29		<u> </u>			1				29
30		 			1				30
31		 			1				31
32		 			1				32
33		!			 				33
			2 20 5 (12	0 0000		0 0000			
34 TOTAL (lines 1 thru 33)		\$	3,395,612	\$ 206,328		\$ 206,328	\$ 0	\$ 528,599	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

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Report Period Beginning:

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Facility Name & ID Number SAINT CLARE HOME
XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

Hold down Control Key and hit L

1	3	 4	<u> </u>	5	6	7	8	9	
	Year		C	urrent Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	I	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12G, Carried Forward		\$	\$	206,328		\$ 206,328	\$	\$ 528,599	1
2				,				,	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34 TOTAL (lines 1 thru 33)		\$ 3,395,612	\$	206,328		\$ 206,328	\$ 0	\$ 528,599	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

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Report Period Beginning:

10/01/00 Ending: Page 12I 09/30/01

To Print this page only Hold down

Facility Name & ID Number SAINT CLARE HOME XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See 1 Improvement Type** [Totals from Page 12H, Carried Forward]	3 Year Constructed	4 Cost 3,395,612	5 Current Book Depreciation 206,328	6 Life in Years	7 Straight Line Depreciation 206,328	8 Adjustments	9 Accumulated Depreciation 528,599	1	Control Key and
Totals from Page 12H, Carried Forward			Depreciation		Depreciation	Adjustments	Depreciation	1	
Totals from Page 12H, Carried Forward	Constructed				Depreciation	Adjustments		1	
Totals from Page 12H, Carried Forward		3,395,612						1	
								2	
								3	
								4	
								5	
								6	
								7	
								8	
								9	
)								10	
								11	
2								12	
3								13	
								14	
								15	
5								16	
								17	
3								18	
								19	
								20	
2								21	
3								23	
7 4								24	
5								25	
5								26	
7								27	
3			-					28	
)								29	
)			-					30	
, , , , , , , , , , , , , , , , , , ,							 	31	
2								32	
3								33	
TOTAL (lines 1 thru 33)		\$ 3,395,612	\$ 206,328		\$ 206,328	S 0	\$ 528,599	34	

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS Page 13

			SIMIL OF I				1 age 15	
Facility Name & ID Number	SAINT CLARE HOME	#	0044024	Report Period Beginning:	10/01/00	Ending:	09/30/01	
XI. OWNERSHIP COSTS (cont	inued)							

OWNERSHIF COSTS (continued)

C. Equipment Do	epreciation-Excludir	ig Transportation.	(See instructions.)

	Cr Equipment Depreciation Excitating	, ,						
	Category of	1	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 413,244	\$ 57,033	\$ 57,033	\$		\$ 212,185	71
72	Current Year Purchases	57,292						72
73	Fully Depreciated Assets	0						73
74								74
75	TOTALS	\$ 470,536	\$ 57,033	\$ 57,033	\$		\$ 212,185	75

D. Vehicle Depreciation (See instructions.)*

	D: venicle Depreciation (See I	,								
	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	E. Summary of Care-Related Assets	1	<u> </u>	
		Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,090,148	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 263,361	82
83	Straight Line Depreciation	(line 70, col.7 + line 75 ,col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 263,361	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation	[(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 740,784	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

- Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.
- ** This must agree with Schedule V line 30, column 8.

Faci	ility Name & I	D Number	SAINT CLARE HO	ME		STATE OF ILLINOI # 0044024		Period Beginning:	10/01/00	Ending:	Page 14 09/30/01
XII.	1. Name of 2. Does the	and Fixed Equip Party Holding L	ment (See instructions. ease: real estate taxes in add		ount shown below (on line 7, column 4?]NO				
		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*				
3	Original Building: Additions	- Constructed	07.2543	s		or Bease	Tenewar option		ective dates of current nning ng	rental agreeme	nt:
5 6 7	TOTAL			\$				_	t to be paid in future y	ears under the	current
	This amo		tization of lease expense ed by dividing the total					Fisca 12 13.	/2001 /2002	Annual Ro	ent
	9. Option to	Buy:	YES	NO Tern	is:	*		14.	/2003	\$	
	15. Is Mova		ensportation and Fixed ental included in buildi able equipment:		instructions.] Description:		NO pment tle detailing the break	sdown of movable eq	uipment'		
	C. Vehicle R	ental (See instru	ctions.)			•		•	,		
17	1 Use		2 Model Year and Make		3 chly Lease syment	4 Rental Expens for this Period \$			there is an option to b		
18 19 20							18 19 20	sc	hedule.		
	TOTAL			s		s	21		pense must agree with		

		STATE OF ILLINOIS					Page 15
Facility Name & ID Number	SAINT CLARE HOME	#	0044024	Report Period Beginning:	10/01/00	Ending:	09/30/01

NG PROGRAMS (Se	e instructions.)			
ined in another facil	ity program, attach a s	chedule listing t	he facility name, add	ress and cost per aide trained in that facility.)
YES	2. CLASSROOM	1 PORTION:		3. CLINICAL PORTION:
NO	IN-HOUSE PI	ROGRAM		IN-HOUSE PROGRAM
	IN OTHER FA	ACILITY		IN OTHER FACILITY
	COMMUNITY	Y COLLEGE		HOURS PER AIDE
	HOURS PER	AIDE		
ALLOCA	ATION OF COSTS	(d)		C. CONTRACTUAL INCOME
1	2	3	4	In the box below record the amount of income you facility received training aides from other facilities
	Facility			
Drop-out:	s Completed	Contract	Total	\$
\$	\$	\$	\$	D AVAILABLE OF AVERGENANCE
				D. NUMBER OF AIDES TRAINED
	U			COMPLETED
	0			1. From this facility
	V			2. From other facilities (f)
				DROP-OUTS
		 		1. From this facility
s	\$	\$	s	2. From other facilities (f)
	ALLOCA	YES 2. CLASSROOM NO IN-HOUSE PI IN OTHER F. COMMUNIT HOURS PER ALLOCATION OF COSTS 1 2 Facility	TYES 2. CLASSROOM PORTION: NO IN-HOUSE PROGRAM IN OTHER FACILITY COMMUNITY COLLEGE HOURS PER AIDE ALLOCATION OF COSTS (d) 1 2 3 Facility Drop-outs Completed Contract \$ \$ \$ \$ \$ 0 0	ALLOCATION OF COSTS (d) 1 2 3 4 Facility Drop-outs Completed Completed Contract S S S O O TEST ST ST ST ST ST ST ST S S O O CLASSROOM PORTION: CLASSROOM PORTION: IN OTHER FACILITY COMMUNITY COLLEGE HOURS PER AIDE ALLOCATION OF COSTS (d) 1 2 3 4 Facility Drop-outs Completed Contract Total S S O O

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

10/01/00

Ending:

09/30/01

0044024 Report Period Beginning:

SAINT CLARE HOME

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

Facility Name & ID Number

XI	V. SPECIAL SERVICES (Direct Cost)	(See instructions.)				_		_		
1	T	1	2	3	4	5	6	7	8	
		Schedule V	Staff			le Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other t	(other than consultant)		Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. $3 + 5 + 6$)	
1	Licensed Occupational Therapist	10a/3	hrs	\$		\$ 60,499	\$		\$ 60,499	1
	Licensed Speech and Language									
2	Development Therapist	10a/3	hrs			35,368			35,368	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			80,334			80,334	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							\Box
9	Pharmacy	39/3	prescrpts				99,320		99,320	9
	Psychological Services									\Box
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
										\Box
13	Other (specify): Lab / X-ray	39/3				8,586			8,586	13
									_	
ĺ										
14	TOTAL			ls		s 184,787	\$ 99,320		\$ 284,107	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Report Period Beginning:
(last day of reporting year) 0044024 As of 09/30/01

Facility Name & ID Number SAINT CLARE HOME

XV. BALANCE SHEET - Unrestricted Operating Fund.

This report must be completed even if financial statements are attached.

		1		2 After	
		O	perating	Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	581,661	\$	1
2	Cash-Patient Deposits		2,970		2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance)		702,996		3
4	Supply Inventory (priced at)				4
5	Short-Term Investments				5
6	Prepaid Insurance		33,874		6
7	Other Prepaid Expenses				7
8	Accounts Receivable (owners or related parties)		0		8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	1,321,501	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land		224,000		13
14	Buildings, at Historical Cost		3,396,130		14
15	Leasehold Improvements, at Historical Cost				15
16	Equipment, at Historical Cost		470,018		16
17	Accumulated Depreciation (book methods)		(740,784)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify):		0		23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	3,349,364	\$	24
	TOTAL ACCETS				
2.5	TOTAL ASSETS	Φ.	4 (50 0 5		2.
25	(sum of lines 10 and 24)	\$	4,670,865	\$	25

		1 0	perating	2 A	fter lidation*
	C. Current Liabilities		1 8		
26	Accounts Payable	\$	282,963	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits		2,970		28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		169,423		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		0		31
32	Accrued Real Estate Taxes(Sch.IX-B)		0		32
33	Accrued Interest Payable		0		33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
	Other		2,000		36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	457,356	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable		0		40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43					43
44					44
	TOTAL Long-Term Liabilities	_			
45	(sum of lines 39 thru 44)	\$		\$	45
1.,	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	457,356	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$	4,213,509	s	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$	4,670,865	s	48

10/01/00

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Ending:

^{*(}See instructions.)

Report Period Beginning: 10/01/00

Ending:

09/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

IAIIC	ILES IN EQUIT I				_
			1		1
			Total		
1	Balance at Beginning of Year, as Previously Reported	\$	4,210,097	1	
2	Restatements (describe):			2	Ī
3	audit Adjustment		0	3	Ī
4				4	Ī
5				5	1
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	4,210,097	6]
	A. Additions (deductions):				
7	NET Income (Loss) (from page 19, line 43)		3,412	7	Ī
8	Aquisitions of Pooled Companies			8	Ī
9	Proceeds from Sale of Stock			9	Ī
10	Stock Options Exercised			10	Ī
11	Contributions and Grants			11	1
12	Expenditures for Specific Purposes			12	Ī
13	Dividends Paid or Other Distributions to Owners	()	13	Ī
14	Donated Property, Plant, and Equipment			14	Ī
15	Other (describe)			15	1
16	Other (describe)			16	Ī
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	3,412	17]
	B. Transfers (Itemize):				
18				18	
19				19	1
20				20	Ī
21				21	1
22				22	1
23	TOTAL Transfers (sum of lines 18-22)	\$		23	1
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	4,213,509	24	*

^{*} This must agree with page 17, line 47.

0044024 Report Period Beginning:

10/01/00

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Ending:

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ 3,788,660	1
2	Discounts and Allowances for all Levels	(523,434)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,265,226	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients		5
6	Therapy	456,143	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 456,143	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11			11
12	Gift and Coffee Shop	31,067	12
13	Barber and Beauty Care	23,283	13
14	Non-Patient Meals		14
	Telephone, Television and Radio		15
16		0	16
17	Sale of Drugs	104,252	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20			20
21		58	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 158,660	23
	D. Non-Operating Revenue		
24		932	24
25	Interest and Other Investment Income***	36,339	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 37,271	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	, , ,	0	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,917,300	30

	guinot expense.		2	
	Expenses		Amount	
	A. Operating Expenses			
31	General Services	\$	724,741	31
32	Health Care		1,824,281	32
33	General Administration		1,045,418	33
	B. Capital Expense			
34	Ownership		298,900	34
	C. Ancillary Expense			
35	Special Cost Centers		20,548	35
36	Provider Participation Fee			36
	D. Other Expenses (specify):			
37			0	37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$	3,913,888	40
41	Income before Income Taxes (line 30 minus line 40)**		3,412	41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	s	3,412	43

*	This must	agree with	page 4,	line 45.	column 4

**	Does this agree with ta	axable income (loss) per Federal Income
	Tax Return?	If not, please attach a reconciliation

^{***} See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number SAINT CLARE HOME

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

1 2** 3

Actually Worked Worker North Paid and Accrued Wages			1	2**	3	4	
Worked Accrued Wages Wage			# of Hrs.	# of Hrs.	Reporting Period	Average	
Director of Nursing							
2 Assistant Director of Nursing 2,367 2,578 48,340 18.75 3 Registered Nurses 7,425 8,225 133,804 16.27 4 Licensed Practical Nurses 19,928 22,386 328,518 14.68 5 Nurse Aides & Orderlies 55,365 60,667 573,466 9.45 6 Nurse Aide Trainees 0 0 0 0 0 7 Licensed Therapist 8 Rehab/Therapy Aides 4,386 4,962 58,649 11.82 9 9 Activity Director 10 Activity Assistants 5,510 6,205 49,784 8.02 1 11 Social Service Workers 1,873 2,196 33,128 15.09 1 1 1 Dietician 1 1 Social Service Supervisor 1 1 Head Cook 1 1 1 Social Service Supervisor 1 1 Head Cook 1 1 1 Social Service Supervisor 1 1 1 1 Social Service Supervisor 1 1 1 Social Service Supervisor 1 1 1 1 Social Service Supervisor 1 1 1 1 Social Service Supervisor 1 1 1 1 Social Service Supervisor 1 1 1 1 Social Service Supervisor 1 1 1 1 Social Service Supervisor 1 1 1 1 Social Service Supervisor 1 1 1 1 Social Service Supervisor 1 1 1 1 Social Service Supervisor 1 1 1 1 Social S							
3 Registered Nurses	1						1
4 Licensed Practical Nurses 19,928 22,386 328,518 14.68 5 Nurse Aides & Orderlies 55,365 60,667 573,466 9.45 5 6 Nurse Aides & Orderlies 0 0 0 0 0 0 0 0 0	_						2
5 Nurse Aides & Orderlies 55,365 60,667 573,466 9.45 6 Nurse Aide Trainees 0 0 0 7 Licensed Therapist 1 1 8 Rehab/Therapy Aides 4,386 4,962 58,649 11.82 9 Activity Director 1 1 1 56,205 49,784 8.02 1 11 Social Service Workers 1,873 2,196 33,128 15.09 1 12 Dietician 1	-					16.27	3
6 Nurse Aide Trainees 0 0 0 0 7 Licensed Therapist 8 Rehab/Therapy Aides 4,386 4,962 58,649 11.82 3 9 Activity Director 10 Activity Assistants 5,510 6,205 49,784 8.02 1 11 Social Service Workers 1,873 2,196 33,128 15.09 1 12 Dietician 1 1 500 Service Supervisor 1 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>4</td></td<>							4
7 Licensed Therapy Aides 4,386 4,962 58,649 11.82 19 Activity Director	-		55,365		573,466	9.45	5
8 Rehab/Therapy Aides 4,386 4,962 58,649 11.82 3 9 Activity Director 9 49,784 8.02 1 10 Activity Assistants 5,510 6,205 49,784 8.02 1 11 Social Service Workers 1,873 2,196 33,128 15.09 1 12 Dietician 1			0	0	0		6
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11 Social Service Workers 1,873 2,196 33,128 15.09 1 12 Dietician							9
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15 Cook Helpers/Assistants 12,595 13,760 187,343 13.62 1 16 Dishwashers							13
16 Dishwashers 1 17 Maintenance Workers 4,591 5,009 65,850 13.15 1 18 Housekeepers 10,706 11,883 97,635 8.22 1 19 Laundry 3,580 4,031 31,459 7.80 1 20 Administrator 2,080 2,080 60,000 28.85 2 21 Assistant Administrator 2 Other Administrative 2 23 Office Manager 2 24 Clerical 8,386 9,273 132,854 14.33 2 2 25 Vocational Instruction 2 26 Academic Instruction 2 26 Academic Instruction 2 27 Medical Director 2 28 Qualified MR Prof. (QMRP) 2 29 Resident Services Coordinator 3 Habilitation Aides (DD Homes) 3 3 Medical Records 3 3 Other (specify) 3 3 3 3 Other (specify) 3 3 3 3 3 3 3 3 3							14
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\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	32	Other Health Care(specify)					32
34 TOTAL (lines 1 - 33) 140,144 154,991 \$ 1,842,390 * \$ 11.89 3	33	Other(specify)					33
	34	TOTAL (lines 1 - 33)	140,144	154,991	\$ 1,842,390 *	\$ 11.89	34

^{*} This total must agree with page 4, column 1, line 45.

Print Preview

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		3,600		36
37	Medical Records Consultant		0		37
38	Nurse Consultant				38
39	Pharmacist Consultant		550		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		875		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 5,025		49

10/01/00

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 9,612		50
51	Licensed Practical Nurses		14,383		51
52	Nurse Aides		83,944		52
53	TOTAL (lines 50 - 52)		\$ 107,939		53

^{**} See instructions.

Page 21 Ending: 09/30/01 Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/00

XIX. SUPPORT SCHEDULE			Th. 1				
A. Administrative Salaries	Owne		D. Employee Benefits and			F. Dues, Fees, Subscriptions and Promo	
Name	Function %			cription	Amount	Description	Amount
Lisa Denning	Administrator	\$ 60,000	Workers' Compensation		\$ 27,032	IDPH License Fee	\$ 0
	<u> </u>		Unemployment Compens	ation Insurance	1,165	Advertising: Employee Recruitment	12,015
	<u> </u>		FICA Taxes		140,943	Health Care Worker Background Chec	
	<u> </u>		Employee Health Insurar	ice	189,805	(Indicate # of checks performed	674
			Employee Meals			Central Office Allocation	
	<u> </u>		Illinois Municipal Retires			Promotional Advertising	3,144
			Employee Hepatitis Vacci	ne	0	Public Relations	3,527
TOTAL (agree to Schedule V,			Employee Benefits -		51,813	Dues and Subscriptions	6,771
(List each licensed administration	tor separately.)	\$ 60,000	Employee Benefits - centr	al office		License and Fees	9,669
B. Administrative - Other							
			100000			Less: Public Relations Expense	(3,527)
Description		Amount	100000			Non-allowable advertising	(57)
		\$				Yellow page advertising	(3,144)
		<u> </u>	TOTAL (agree to Schede	ıle V,	\$ 410,758	TOTAL (agree to Sch. V,	\$ 29,072
		<u> </u>	line 22, col.8)			line 20, col. 8)	
TOTAL (agree to Schedule V,	, ,	\$	E. Schedule of Non-Cash			G. Schedule of Travel and Seminar**	
(Attach a copy of any manager	ment service agreement)		to Owners or Employe	ees			
C. Professional Services						Description	Amount
Vendor/Payee	Type	Amount	Description	Line #	Amount		
Heritage Enterprises	Management Fees	\$ 236,401			\$	Out-of-State Travel	
OSF Healthcare	Management Fees	20,664	100000				<u> </u>
OSF Healthcare	Pastoral Services	3,808	100000				<u> </u>
Advantage Behavioral	EAP Services	141				In-State Travel	
Morehead Assoc	Employee Survey	2,988	100000				2,018
SMS Inc.	Medicare Consulting	3,053	100000				157
KPMG	Audit	3,000					_
Hartweg, Muller	Legal	4,043				Seminar Expense	1,549
						Non Allowable	(1,725)
		0				Central Office Allocation	
		0					
		0				Entertainment Expense	_ ()
TOTAL (agree to Schedule V,	line 19, column 3)		TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$250	0 attach copy of invoices.)	\$ 274,098			-	TOTAL line 24, col. 8)	\$ 1,999
	FV	- ,,,,	* A44L			. ,	

* Attach copy of IMRF notifications

**See instructions.

0044024

Report Period Beginning:

10/01/00 **Ending:** Page 22 09/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year						Amount of	Expense Amorti	zed Per Year			
	Improvement	Improvement	Total Cost	Useful									1
	Type	Was Made		Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
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20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility	Name & ID Number SAINT CLARE HOME		age 23 9/30/01
	NERAL INFORMATION:	# 0077027 Report Letton Deginning. 10/01/00 Enumg. 02	7/30/01
	Are nursing employees (RN,LPN,NA) represented by a union?	(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified	
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. Illinois Healthcare Association	in the Ancillary Section of Schedule V? yes	
(3)	Did the nursing home make political contributions or payments to a politica action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes	(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions	
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity?	(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? ves Indicate the amount. \$ 3,495	
(5)	Have you properly capitalized all major repairs and equipment purchases: What was the average life used for new equipment added during this period? yes 7 years	(16) Travel and Transportation a. Are there costs included for out-of-state travel?	_
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.	If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation residents? no If YES, please indicate the amount of income earned from su	
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.	program during this reporting period. \$ c. What percent of all travel expense relates to transportation of nurses and patients? d. Have vehicle usage logs been maintained? yes	100%
(8)	Are you presently operating under a sale and leaseback arrangement. If YES, give effective date of lease.	e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes f. Has the cost for commuting or other personal use of autos been adjusted	
(9)	Are you presently operating under a sublease agreement? YES xx NO	out of the cost report? yes g. Does the facility transport residents to and from day training?	0
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO xx If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over	Indicate the amount of income earned from providing such transportation during this reporting period.	
		(17) Has an audit been performed by an independent certified public accounting firm? you Firm Name: KPMG The instruction	ns for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 51,465 This amount is to be recorded on line 42 of Schedule V.	cost report require that a copy of this audit be included with the cost report. Has this copbeen attached? no If no, please explain. Not complete as of the filing	
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.	(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes yes	
		(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Attach invoices and a summary of services for all architect and appraisal fees.	

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